Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

Report of an inspection of a Designated Centre for Disabilities (Adults).

Issued by the Chief Inspector

Name of designated centre:	Acorn Respite & Residential Services
Name of provider:	Western Care Association
Address of centre:	Mayo
Type of inspection:	Unannounced
Date of inspection:	28 February 2024
Centre ID:	OSV-0003914
Fieldwork ID:	MON-0040744

About the designated centre

The following information has been submitted by the registered provider and describes the service they provide.

Acorn Respite and Residential Services is a centre operated by Western Care Association. The centre provides respite and residential care for up to nine male and female residents, who are over the age of 18 years and who have an intellectual disability. The centre comprises of two houses located on the outskirts of a town in Co. Mayo, situated within close proximity to each other. Residents have their own bedroom, en-suite and shared bathroomfacilities are available, kitchen and dining areas, sitting rooms, staff office, utility and garden area. Staff are on duty both day and night to support the residents who live here.

The following information outlines some additional data on this centre.

Number of residents on the date of inspection:	9

How we inspect

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended). To prepare for this inspection the inspector of social services (**hereafter referred to as inspectors**) reviewed all information about this centre. This included any previous inspection findings, registration information, information submitted by the provider or person in charge and other unsolicited information since the last inspection.

As part of our inspection, where possible, we:

- speak with residents and the people who visit them to find out their experience of the service,
- talk with staff and management to find out how they plan, deliver and monitor the care and support services that are provided to people who live in the centre,
- observe practice and daily life to see if it reflects what people tell us,
- review documents to see if appropriate records are kept and that they reflect practice and what people tell us.

In order to summarise our inspection findings and to describe how well a service is doing, we group and report on the regulations under two dimensions of:

1. Capacity and capability of the service:

This section describes the leadership and management of the centre and how effective it is in ensuring that a good quality and safe service is being provided. It outlines how people who work in the centre are recruited and trained and whether there are appropriate systems and processes in place to underpin the safe delivery and oversight of the service.

2. Quality and safety of the service:

This section describes the care and support people receive and if it was of a good quality and ensured people were safe. It includes information about the care and supports available for people and the environment in which they live.

A full list of all regulations and the dimension they are reported under can be seen in Appendix 1.

This inspection was carried out during the following times:

Date	Times of Inspection	Inspector	Role
Wednesday 28 February 2024	09:00hrs to 17:00hrs	Catherine Glynn	Lead
Wednesday 28 February 2024	09:00hrs to 17:00hrs	Mary McCann	Lead

What residents told us and what inspectors observed

This inspection was completed to monitor the compliance with the regulations following the last inspection completed in March 2023 as part of the targeted safeguarding inspection programme. Overall, this inspection found significant areas for improvement, however the service provided was person centred, however the provider had identified that this centre was not suitable to meet the needs of residents living in this centre. Significant improvements required included; fire safety, governance and management, risk and premises, and these will be discussed throughout the report.

This centre is run by Western Care Association in co. Mayo. Due to concerns about the governance and oversight of Western Care Association centres and its impact on the well-being and safety of residents, the Chief Inspector of Social Services undertook a targeted safeguarding inspection programme which took place over two weeks in March 2023 and focused on regulation 7 (positive behaviour support), regulation 8 (Protection), regulation 23 (governance and management) and regulation 26 (risk management procedures). The overview report of this review has been published on the HIQA website. in response to the findings of this review, Western Care Association submitted a compliance plan describing all actions to be undertaken to strengthen these arrangements and ensure sustained compliance with the regulations. Inspectors have now commenced a programme of inspections to verify whether these actions have been implemented as set out by Western Care Association, but also to assess whether the actions have been effective on their governance, oversight and safeguarding in centres for people with disabilities in Co. Mayo. At the time of this inspection a number of actions had been implemented, with more in progress for completion. The provider had made improvements improvements in their governance arrangements. These had occurred in line with timeframes of the provider's compliance plan and the management team met with said that there had been positive changes with regard to communication systems.

On arrival to the centre, inspectors met with the person in charge and two staff members during the inspection. The person in charge is also the Regional manager of the service, but had recently commenced two weeks prior to the inspection as person in charge due to recruitment issues at present. Inspectors gave a document called 'nice to meet you' that inspectors use with the aim of supporting residents to understand the purpose of their visit. In one house residents were attending their day programme and in the second house residents were not due to attend for respite on the day of the inspection. Inspector had the opportunity to meet two residents in the afternoon on their return from their day services. Both residents were observed clearly communicating their choices and preferences with staff on duty and were noted to be at ease throughout this observation. Both residents were also observed to have mobility issues but they were very familiar, comfortable and at ease with their environment.

Through a review of documentation and discussions with staff and the management

team, inspectors could see that residents were supported to attend activities that were meaningful to them, This included a structured week that included attending scheduled day services and doing various recreational activities in the wider community and in the centre.

A walk around of both houses was completed as house one was part of a review of the service following the inspection completed in March 2023, and house two was closed for renovations at the time of that inspection. House two had required renovation and remodeling which was now completed. Inspectors found that house two met the requirements of the regulations and was suitably decorated and furnished to meet the needs of residents attending for respite. The management team had further plans to personalise the house once all residents were familiar and established in their attendance to respite. Inspectors found that house one was also under review with the management team, as they had recognised the aging needs of the residents was changing and they were reviewing potential properties in the area to meet the residents aging needs, however there was no clear time bound plan in place at the time of the inspection. In house one; inspectors observed that while the provider had attempted to address a mould issue in two rooms, but the cause had not been investigated with inspectors noting that mould damage remained evident to the paintwork. During the inspection there was also a malodour noted in the main bathroom which the provider had not fully investigated.

Inspectors found that significant fire safety issues remained outstanding since 2021 regardless of repeated reports from a suitably qualified person highlighting the areas for improvement, with the latest external report being completed in July 2023. Furthermore, significant works were required in house one to maintain and improve the living environment to meet the needs of the residents. this again with be outlined in the next two sections of the report.

The next two sections of this report present the inspection findings in relation to the governance and management in the centre, and describes about how governance and management affects the quality and safety of the service provided.

Capacity and capability

The inspection found that the governance and management arrangements in the centre required improvement and that while the provider's compliance plan response to the targeted inspection programme in 2023 was achieving steady progress, additional areas for improvement were identified during this inspection. These included addressing outstanding fire safety works which had been initially identified in 2021, improving risk management arrangements and enhancing governance to ensure compliance with the regulations. These areas of improvement will be elaborated on throughout the following sections of the report.

The provider had made progress with a number of actions from the overview report, which will be discussed under each of the relevant regulations. The local

management team spoke about positive improvements to communication between the provider's management structures. However, inspectors found that further improvement in oversight was required in this centre. Inspectors found that recent changes in local management at the centre had resulted in lapses in practices. For example, staff had not received formal supervision for five and a half months prior to the inspection, audit outcomes had not been addressed such as fire reports recommendations since 2021, fire drills completed or a review of documentation such as personal emergency evacuation plans (PEEPS). Other audits were carried out by the staff team which included a monthly audit plan.These included audits of fire safety, finances, health and safety, medication and infection control. Inspectors found that while audits were completed, identified improvements were unclear as whether actions had been taken or completed at the time of the inspection. For example, a bathroom that had a strong malodour, although reported and subsequently painted had not involved an investigation into the cause.

The management arrangements in place in the centre required review. While the newly appointed person in charge had familiarity with the residents, inspectors found that due to their extensive role and responsibilities they were not regularly present in the centre. The person in charge was also a regional manager with responsibility for day services, residential services and individualised services. While staff stated that the person in charge was available via the telephone, there attendance at the centre was limited and not evident in the staff roster. Inspectors also found that the on call arrangement for the centre had not yet been addressed by the provider, with reliance on the person in charge and regional manager outside of office hours who at this time were the same person.

Overall, the provider had not ensured that there were effective systems in place to provide a good quality service to residents, with significant improvements being required to areas such as fire safety, risk management and premise which will be outlined in the next section of the report.

Regulation 15: Staffing

The number, skill-mix and qualification of staff was appropriate to the number and assessed needs of residents. As a result residents received opportunities to engage in activities of their preferences in the house, day service and local community.

Judgment: Compliant

Regulation 16: Training and staff development

The provider had not ensured that staff development was prioritised and that staff teams had access to formal support and supervision consistently at the time of the

inspection. Inspectors found that supervision was not completed in five and a half months at the time of the inspection. While, team meetings were completed, these had not been undertaken with a full staff compliment since October 2023.

Judgment: Substantially compliant

Regulation 23: Governance and management

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete 12 actions aimed at improving governance arrangements at the centre. The provider aimed to have all actions completed by 31/10/2024. At the time of the inspection eight actions had been implemented with the remainder in progress.

Completed actions included an assessment of the senior and front line management structures and the reconfiguration of service areas, the establishment of a new incident monitoring and oversight committee and a reinstated human rights committee, and the introduction of new arrangements for announced provider visits.

Inspectors found that four actions had commenced and were progressing as part of the compliance plan response to the targeted inspections in 2023. This included:

- the quality and safety and service improvement department were finalising the review of service audits.
- The governance and quality improvement framework was in draft form and under review.
- A training and development project group was established and they had selected an information system which would enhance and support the staff training arrangements in place.
- Although the review of the policy, procedures and guidelines was not yet completed by the provider, not all were finalised and circulated at the time of the inspection.

Inspectors found that the person in charge was well aware of the ongoing actions taken by the provider to strengthen the governance and management arrangements at both provider and service level. They spoke about improvements in communication arrangements, however they clearly showed inspectors that these systems required further improvement in this centre in regard to consistency of the management systems in place. That while improvements had an organisational impact on the quality and safety of service provided, this centre had significant improvements required locally.

A recent provider led audit failed to recognise or identify gaps found during this inspection, therefore no clear time-bound plan was in place to address the deficits. Inspectors also noted that as the person in charge had gone on unplanned leave from October 2023 and was not replaced until the regional manager stepped in as

person in charge as a temporary measure in mid February 2024, therefore the oversight of this service was not as effective or present as required by the regulations.

The provider had an appropriate management structure in place, however significant improvement was required to ensure a comprehensive review of this service with time-bound actions to address all areas that required improvement was commenced and completed. This includes:

- the provider had failed to identify deficits in this service.
- documentation reviewed had gaps noted and was not identified.
- the on-call system was not sustainable at the time of the inspection.
- a time bound actions plan was not in place that included all areas for improvement.
- the staff roster did not show or reflect the person in charge attendance of time at the centre.
- the provider had not addressed recommendations from fire reports since 2021.
- Staff supervision had not been completed for five months.
- A review of audits did not show action or oversight by the management team.
- Risks were not reflective of risk evident in centre, for example house one premises was not listed as requiring replacement.
- Fire was shown on the risk register but was not risk rated appropriately due to outstanding actions since 2021.
- Maintenance required in the centre was disjointed and did not show a clear time bound plan.
- While the provider had identified a replacement property was required for house one, there was no time bound plan in place at the time of the inspection.

Judgment: Not compliant

Quality and safety

Inspectors found that the service provided in Acorn residential and respite services required significant improvements in fire safety, governance, premises and risk management to enhance the quality of care and support provided. This included addressing actions identified in fire safety reports since 2021, reviewing house one's premises to ensure it met the needs of the residents and their aging profile.

The provider had not ensured that residents' personal plans were reviewed or monitored effectively. Inspectors found on a review of a sample of personal plans; that Personal Emergency Evacuation Plans (PEEPs) were unclear and provided conflicting information for staff supporting the residents.

While the provider had effective fire systems in house two which included fire detection, fire safety checks and emergency lighting. House one required significant improvements in areas such as fire drills and fire safety checks. More importantly, the provider had failed to address actions identified in fire risk reports dating back to 2021.

Inspectors found that the risk management in the centre required significant improvement. Fire safety works had not been appropriately risk rated and premises issues had not been addressed such as the bathroom's ongoing malodour in main bathroom, damp in an en-suite bathroom, and the suitability of the premises to the residents' changing needs.

The premises provided in house two was clean, comfortable and suitably decorated; however, house one required significant improvements due to paintwork damaged in the sitting room, office, hallway and communal areas of the house. Further, actions are listed in this report relating to mould in one en-suite, malodour in the main bathroom and damaged flooring in the staff office, hallway, sitting room and kitchen area in house one. Inspectors found that although some of these issues had been reported to the provider, a time bound plan on how they were to be addressed had not been developed.

Overall, inspectors found that the care within the service was not delivered in a manner to enhance the quality and safety of all residents. There was poor governance and management arrangements in place which impacted on residents.

Regulation 13: General welfare and development

Residents living in this centre were supported to engage in activities of their preference and choice, and were also receiving appropriate supports based on their assessed needs.

Judgment: Compliant

Regulation 17: Premises

One house required various work and inspectors found that while staff and the management team were aware of actions required, this was not actioned in a clear and comprehensive quality improvement plan with time-bound actions to address the works required,

- paintwork throughout

- flooring in all downstairs required review in one house as inspectors saw that the flooring was worn, marks were evident and carpet on the stairwell was worn, and

discoloured.

-Kitchen cabinets required review as inspectors noted that doors were aged, worn, some were not closing effectively and were not closing appropriately.

-Malodour in a communal bathroom was evident and required review, as identified in an unannounced audit completed in December 2023. Mould was also evident in this room due to wear and discolouration of the paintwork.

- A light switch on a stairs required review as the button for activating was not in place at the time of the inspection and was not working effectively. It was also unclear of a review of electrical systems was completed in this centre as this house was aged with existing lighting from the opening of this centre still in place at the time of the inspection.

- Storage required review in the house as vegetables were observed stored in the laundry facilities.

Judgment: Not compliant

Regulation 26: Risk management procedures

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete three actions aimed at improving risk management arrangements at the centre. The provider aimed to have all actions completed by 31/10/2023. At the time of the inspection two actions were completed and one was in progress.

The actions related to ongoing review of quarterly incidents by the incident monitoring and oversight committee, minutes of incidents which were available for review. The local management team spoke of the benefit of this in seeing trends in incidents occurring and in supporting risk identification.

- The action relating to incident management training and a review of the risk management policy and procedure was reported to be in progress, with a trial of training completed by the provider, and further training events to occur when the policy was formalised and established.

However, inspectors found significant areas for improvement in this centre which were not all clearly shown or highlighted effectively, this included:

- Risk ratings did not reflect the risk evident in the centre at the time of the inspection, for example:

- outstanding fire works required from 2021 were risk rated as yellow and this remained outstanding at the time of the inspection, with no clear time bound plan in place to complete this work.This included in one house; replacement of all fire doors

including seals and suitable fire hinges as well as replacement of the doors.

- The boiler house also required review as highlighted in the fire reports completed by a competent person from 2021, this was also highlighted as urgent due to the close proximity of the boiler house to one hous

- An external report from 2023 had also hghlighted areas for improvement in July 2023 which were not adressed at the time of the inspection, such as removal of soft furnishing on a fire exit door from a residents bedroom.

- personal emergency evacuation plans were unclear and inspectors found duplicates in place with conflicting information.

- fire drills completed, did not show learning or were not reviewed by the management team to ensure that they monitored and reviewed as required.

- Failed to risk assess storage of food stored in open containers in close proximity to laundry facilities where a strong smell of cleaning products was evident at the time of the inspection.

- failure to risk assess mould evident in one bedroom while effforts had been made to address the mould by their maintenance team this had not been effective. Therefore further action is required from a competent person to ensure the environment for mould growth was eliminated.

- Failed to risk assess malodour in main bathroom and put controls on place to mitigate the risk.

Judgment: Not compliant

Regulation 28: Fire precautions

Inspectors found that the provider had failed to ensure that effective fire systems were in place in all houses in this centre. Improvements were required relating to both the addressing of fire improvements dating back to 2021 and the ongoing monitoring of arrangements at the centre.

- Residents PEEPs were unclear and provided conflicting information to staff
- Fire drills dd not include shared learning to ensure their effectiveness
- Fire safety audits did not identify gaps
- Fire doors required appropriate hinges and seals as identified in external fire reports,
- A review of fire exit points by a competent person was identified to ensure they meet regulatory requirements.
- The boiler house required appropriate fire retardant works as identified in external fire reports
- Suitable seals were recommended for all pipe work,

- A suitable fire valve is fitted and operational on the heating boiler.

Judgment: Not compliant

Regulation 7: Positive behavioural support

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete seven actions aimed at improving behaviour support arrangements at the centre. The provider aimed to have all actions completed by 30/06/2024. At the time of the inspection the provider had completed six of theses actions. The seventh action had commenced and was in progress.

Completed actions included the appointment of an interim head of clinical and community support and appointment of additional multi-disciplinary supports. Under the leadership of the psychology team, a governance and clinical oversight group and a behaviour support oversight group was established in order to coordinate the response to critical incidents. A review of the role and function of the psychology team was completed and guidance on the referral pathways was developed.

The inspector found that one action was still in progress relating to the development of training on neurodiversity. A pilot had been completed with a full roll out of the training planned.

In this centre, inspectors found that residents that required support with positive behaviour support had specialist supports in place. The policy on behaviour support was up-to-date and staff training was provided.

Judgment: Substantially compliant

Regulation 8: Protection

In response to the targeted safeguarding inspection programme, the provider had committed through its compliance plan to complete five actions aimed at improving safeguarding arrangements at the centre. The provider aimed to have all actions by 31/10/2023. At the time of the inspection, all actions were completed.

These included the establishment of a safeguarding oversight committee, updating of the provider's safeguarding and protection policy and the introduction of a six monthly review process for any open safeguarding plans. In addition, staff had access to face-to-face safeguarding and protection training and new systems were in place to improve staff awareness of the contents and actions of open safeguarding plans.

At this centre, inspectors found that residents were supported to understand the need for self-care and protection. If safeguarding plans were used, the inspector found that the team had a good awareness of the plans requirements and that the actions were integrated into the behaviour support strategies and personal risk management plans.
Judgment: Compliant

Appendix 1 - Full list of regulations considered under each dimension

This inspection was carried out to assess compliance with the Health Act 2007 (as amended), the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013, and the Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults) with Disabilities) Regulations 2013 (as amended) and the regulations considered on this inspection were:

Regulation Title	Judgment
Capacity and capability	
Regulation 15: Staffing	Compliant
Regulation 16: Training and staff development	Substantially compliant
Regulation 23: Governance and management	Not compliant
Quality and safety	
Regulation 13: General welfare and development	Compliant
Regulation 17: Premises	Not compliant
Regulation 26: Risk management procedures	Not compliant
Regulation 28: Fire precautions	Not compliant
Regulation 7: Positive behavioural support	Substantially compliant
Regulation 8: Protection	Compliant

Compliance Plan for Acorn Respite & Residential Services OSV-0003914

Inspection ID: MON-0040744

Date of inspection: 28/02/2024

Introduction and instruction
This document sets out the regulations where it has been assessed that the provider or person in charge are not compliant with the Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children And Adults) With Disabilities) Regulations 2013, Health Act 2007 (Registration of Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013 and the National Standards for Residential Services for Children and Adults with Disabilities.

This document is divided into two sections:

Section 1 is the compliance plan. It outlines which regulations the provider or person in charge must take action on to comply. In this section the provider or person in charge must consider the overall regulation when responding and not just the individual non compliances as listed section 2.

Section 2 is the list of all regulations where it has been assessed the provider or person in charge is not compliant. Each regulation is risk assessed as to the impact of the non-compliance on the safety, health and welfare of residents using the service.

A finding of:

- **Substantially compliant -** A judgment of substantially compliant means that the provider or person in charge has generally met the requirements of the regulation but some action is required to be fully compliant. This finding will have a risk rating of yellow which is low risk.

- **Not compliant -** A judgment of not compliant means the provider or person in charge has not complied with a regulation and considerable action is required to come into compliance. Continued non-compliance or where the non-compliance poses a significant risk to the safety, health and welfare of residents using the service will be risk rated red (high risk) and the inspector have identified the date by which the provider must comply. Where the non-compliance does not pose a risk to the safety, health and welfare of residents using the service it is risk rated orange (moderate risk) and the provider must take action *within a reasonable timeframe* to come into compliance.

Section 1

The provider and or the person in charge is required to set out what action they have taken or intend to take to comply with the regulation in order to bring the centre back into compliance. The plan should be **SMART** in nature. **S**pecific to that regulation, **M**easurable so that they can monitor progress, **A**chievable and **R**ealistic, and **T**ime bound. The response must consider the details and risk rating of each regulation set out in section 2 when making the response. It is the provider's responsibility to ensure they implement the actions within the timeframe.

Compliance plan provider's response:

Regulation Heading	**Judgment**
Regulation 16: Training and staff development	Substantially Compliant
Outline how you are going to come into compliance with Regulation 16: Training and staff development: A schedule of staff support and supervision is complete until the end of the year. Team meetings are scheduled for the year. Staff that cannot attend a meeting are required to read the minutes upon return to work.	
Regulation 23: Governance and management	Not Compliant
Outline how you are going to come into compliance with Regulation 23: Governance and management: A manager has been recruited and commences in the role on the 22.04.24. Six monthly provider led audits will ensure actions identified are time bound and reflective of concerns in the centre. The Area Manager will lead out an evaluation project locally in conjunction with the QSSI department to evaluate record keeping and develop recommendations based on findings. The HSE requested further information in relation to the business case for on call. This information was provided and awaiting feedback from same. Current on call arrangement is in place using the line management contact up to and including Senior Management Team. An interim arrangement is being developed with Front Line Manager through the Area	

Teams agree a system- 30.06.2024

A comprehensive time bound plan is established for areas of improvement, this will be lead out by the Person in charge and manager.

The Person in charges hours in the DCD are now reflected on the roster.

The required Fire works are in progress;

• Replacement of fire doors will be complete by the 31.07.24
• Boiler house works will be complete by the 10.05.24.

A schedule of staff support and supervision is complete until the end of the year.

Schedule of audits to be reviewed in conjunction with the QSSI department. The recruitment of a new manager to fill the vacancy will support the Person in charge with oversight and timely actions.

Fire audits will be reviewed to ensure they are effective, this will be done along with the QSSI department and will be complete by the 31.05.24.

The risk register will be reviewed to ensure risks identified are reflective of risk evident in the centre.

Maintenance plans have been reviewed by the Properties and Facilities lead, they are time bound and completed to limit impact on residents.

The Properties and Facilities lead has engaged with the local council regarding a new property is planned, the lead time on this development is 2028.

All Personal Evacuation Plans (PEEPs) will be updated to ensure they are clear and consistent for all residents.

A fire drill planner is in place for all staff until the end of the year to include a night and day drill. Fire drills will be reviewed by the Person in Charge to ensure learning and ongoing monitoring.

Regulation 17: Premises	Not Compliant

Outline how you are going to come into compliance with Regulation 17: Premises:
The following actions relate to house one;

• Painting throughout will be completed by the 30.09.24.

• Flooring & carpet will be upgraded by the 31.05.24.

A new kitchen will be installed by the 30.09.24 along with a utility upgrade to enhance storage.

Malodour investigations are ongoing with an expected finalization of works by the 31.05.24.

The electrical systems were reviewed by a competent person. Any works required were rectified at this time.

Storage of vegetables is now in line with food safety guidelines.

The review of mould will be undertaken by a specialist surveyor by the 20.05.24.

Regulation 26: Risk management procedures	Not Compliant

Outline how you are going to come into compliance with Regulation 26: Risk management procedures:
The risk register will be updated to ensure it is reflective of risks evident in the centre.

When the incident injury policy is released training will be provided to staff teams- pilot 29.04.2024.

Risk management policy will be released and training will be provided to staff teams 07.05.24.

The incident management policy, risk management p0olicy and associated training modules are in consultation stage with various stakeholders for organisational implementational. The pilot project will explore technical solutions for audit management to ensure consistency across the organisation along with a systematic scoping review 29.04.24.

Neurodiversity training for managers commenced on the 29th of February. Dates for future events have been scheduled commencing on 11th of April.

The HSE requested further information in relation to the business case for on call. This information was provided and awaiting feedback from same. Current on call arrangement is in place using the line management contact up to and including Senior Management Team.
An interim arrangement is being developed with Front Line Manager through the Area Teams agree a system- 30.06.2024

All Personal Evacuation Plans (PEEPs) will be updated to ensure they are clear and consistent for all residents.

A fire drill planner is in place for all staff until the end of the year to include a night and day drill. Fire drills will be reviewed by the Person in Charge to ensure learning and ongoing monitoring.

Storage of vegetables is now in line with food safety guidelines.

The review of mould will be undertaken by a specialist surveyor by the 20.05.24.

Malodour investigations are ongoing with an expected finalization of works by the 31.05.24.

Regulation 28: Fire precautions	Not Compliant

Outline how you are going to come into compliance with Regulation 28: Fire precautions:
All Personal Evacuation Plans (PEEPs) will be updated to ensure they are clear and consistent for all residents.

Fire drills will be reviewed by the Person in Charge to ensure learning and ongoing monitoring.

Fire audits will be reviewed to ensure they are effective, this will be done along with the QSSI department and will be complete by the 31.05.24.

The required Fire works are in progress;

- Replacement of fire doors will be complete by the 31.07.24
- Boiler house works will be complete by the 10.05.24.

Regulation 7: Positive behavioural support	Substantially Compliant

Outline how you are going to come into compliance with Regulation 7: Positive behavioural support:
Neurodiversity training for managers commenced on 29th of February. Dates for future

events have been scheduled, commencing on April 11th.

Section 2:

Regulations to be complied with

The provider or person in charge must consider the details and risk rating of the following regulations when completing the compliance plan in section 1. Where a regulation has been risk rated red (high risk) the inspector has set out the date by which the provider or person in charge must comply. Where a regulation has been risk rated yellow (low risk) or orange (moderate risk) the provider must include a date (DD Month YY) of when they will be compliant.

The registered provider or person in charge has failed to comply with the following regulation(s).

Regulation	Regulatory requirement	Judgment	Risk rating	Date to be complied with
Regulation 16(1)(b)	The person in charge shall ensure that staff are appropriately supervised.	Substantially Compliant	Yellow	31/05/2024
Regulation 17(1)(a)	The registered provider shall ensure the premises of the designated centre are designed and laid out to meet the aims and objectives of the service and the number and needs of residents.	Not Compliant	Orange	30/09/2024
Regulation 17(1)(b)	The registered provider shall ensure the premises of the designated centre are of sound construction and kept in a good state of repair externally and internally.	Not Compliant	Orange	30/09/2024
Regulation 17(1)(c)	The registered provider shall ensure the premises of the	Not Compliant	Orange	30/09/2024

	designated centre are clean and suitably decorated.			
Regulation 23(1)(c)	The registered provider shall ensure that management systems are in place in the designated centre to ensure that the service provided is safe, appropriate to residents' needs, consistent and effectively monitored.	Not Compliant	Orange	31/10/2024
Regulation 23(1)(d)	The registered provider shall ensure that there is an annual review of the quality and safety of care and support in the designated centre and that such care and support is in accordance with standards.	Not Compliant	Orange	31/05/2024
Regulation 23(2)(a)	The registered provider, or a person nominated by the registered provider, shall carry out an unannounced visit to the designated centre at least once every six months or more frequently as determined by the chief inspector and shall prepare a written report on the safety and quality of care and support provided in the centre and	Not Compliant	Orange	30/06/2024

	put a plan in place to address any concerns regarding the standard of care and support.			
Regulation 23(3)(a)	The registered provider shall ensure that effective arrangements are in place to support, develop and performance manage all members of the workforce to exercise their personal and professional responsibility for the quality and safety of the services that they are delivering.	Not Compliant	Orange	31/10/2024
Regulation 26(1)(a)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: hazard identification and assessment of risks throughout the designated centre.	Not Compliant	Orange	30/06/2024
Regulation 26(1)(b)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: the measures and actions in place to	Not Compliant	Orange	30/06/2024

	control the risks identified.			
Regulation 26(1)(e)	The registered provider shall ensure that the risk management policy, referred to in paragraph 16 of Schedule 5, includes the following: arrangements to ensure that risk control measures are proportional to the risk identified, and that any adverse impact such measures might have on the resident's quality of life have been considered.	Not Compliant	Orange	30/06/2024
Regulation 26(2)	The registered provider shall ensure that there are systems in place in the designated centre for the assessment, management and ongoing review of risk, including a system for responding to emergencies.	Substantially Compliant	Yellow	30/06/2024
Regulation 28(1)	The registered provider shall ensure that effective fire safety management systems are in place.	Not Compliant	Orange	31/07/2024
Regulation 28(2)(a)	The registered provider shall take adequate precautions against the risk of	Not Compliant	Orange	31/07/2024

	fire in the designated centre, and, in that regard, provide suitable fire fighting equipment, building services, bedding and furnishings.			
Regulation 28(2)(b)(i)	The registered provider shall make adequate arrangements for maintaining of all fire equipment, means of escape, building fabric and building services.	Not Compliant	Orange	31/07/2024
Regulation 28(2)(b)(ii)	The registered provider shall make adequate arrangements for reviewing fire precautions.	Not Compliant	Orange	31/07/2024
Regulation 28(4)(a)	The registered provider shall make arrangements for staff to receive suitable training in fire prevention, emergency procedures, building layout and escape routes, location of fire alarm call points and first aid fire fighting equipment, fire control techniques and arrangements for the evacuation of residents.	Not Compliant	Orange	31/07/2024
Regulation 28(4)(b)	The registered provider shall ensure, by means of fire safety	Not Compliant	Orange	31/07/2024

	management and fire drills at suitable intervals, that staff and, in so far as is reasonably practicable, residents, are aware of the procedure to be followed in the case of fire.			
Regulation 07(4)	The registered provider shall ensure that, where restrictive procedures including physical, chemical or environmental restraint are used, such procedures are applied in accordance with national policy and evidence based practice.	Substantially Compliant	Yellow	30/06/2024